Is Hysteria Ever a Justifiable Diagnosis in Gynecology?—In view of the tendency, which is of late becoming manifest, to ascribe many symptoms apparently referable to the female genital system to psychic disturbances alone, SIPPEL (*Deutsch. med. Woch.*, 1913, xxxix, 263) thinks that a word of warning is in place. Many such cases, especially if no definite pathological condition can be made out by the ordinary examination, are put down as "hysteria," a diagnosis which in the vast majority of cases not only expresses the inability of the attending physician to discover the real trouble, but carries with it two unfortunate sequelæ—failure to relieve the patient of real distress, and the transformation of an originally nervously sound woman into a true neurasthenic because of this failure, and of the knowledge that she is being wrongly judged. Sippel urges that the diagnosis "hysteria" should never be made until most careful and repeated examinations have failed to reveal any demonstrable local lesion, and that even then the possibility of a purely psychic origin of definite pain should be regarded with much skepticism, believing rather that most of these cases merely indicate our inability always to diagnosticate minor anatomical changes. A most useful method of arriving at the true diagnosis in many of these cases has been, in his experience, to have the patient anesthetized merely to the point where sensibility and the ordinary reflexes are just barely lost. If now a reflex can be elicited by pressure on the region complained of by the patient, proof is furnished that an actual physical lesion exists. In cases of a somewhat different category—where a tumor can be felt in the pelvis, but its origin cannot be determined—the employment of the exaggerated Trendelenburg position, in addition to light narcosis, may be of the greatest help. Under these conditions, adnexal tumors will fall sufficiently away from the uterus to be easily differentiated from it, even though with the patient in the ordinary position on the examining table this may have been impossible.

Postoperative Infection of the Urinary Tract.—In order to determine by what routes pathogenic organisms most commonly reach the bladder and upper urinary tract after operation, BAUEREISEN (*Zeitschr. f. gyn. Urologie*, 1913, iv, 1) has made an examination of the organs removed at autopsy from 18 postoperative cases, the majority of these having been Wertheim operations for carcinoma of the cervix. He has found that organisms reach the bladder, in the vast majority of cases, through the urethra, either by spontaneous ascension, or as the result of catheterization. In a few instances, organisms may get to the bladder by way of the blood current, after passing the kidneys; this is especially true of colon bacilli. In the urethras of normal women, not confined to bed, staphylococci are always present, and colon bacilli in 60 per cent.; in bed patients, the colon bacillus also is present in all cases. After a radical cancer operation, the secretion from the wound cavity, rich in pathogenic organisms, flows out through the vagina past the urethral orifice, so that the urethra becomes abnormally rich in bacteria, and it is in this way that they get into the bladder. Only very rarely, apparently, does direct propagation or transportation through the vesical wall take place, this being prevented by the wall of inflammatory tissue that forms in its outer portion, and also by the adverse lymph current. Infection of the ureter usually occurs in a similar manner—by direct ascension through the lumen, aided perhaps by postoperative over-distention of the bladder. The same factors prevent the transmission of organisms through the ureteral as through the vesical wall. The kidneys are infected most commonly by ascension through the ureter, less frequently through the blood current. In the latter cases the organisms originate from the operative area, not from the intestine, becoming scattered into the blood during the operation, and then partially excreted by the kidney. Of the organisms which may infect the kidney in this manner, the staphylococcus is unquestionably the most dangerous. Once the renal cortex is involved, the organisms may spread to the capsule and cause a perinephric infection. For the fatty capsule, still another mode of infection must be taken into consideration, however, the lymph channels in the connective tissue along the ureters from the true pelvis to the kidneys. Infection by this route causes a perinephritis, which may spread secondarily to the kidney substance.

Influence of Myomas on the Blood Supply of the Uterus.—In continuation of some studies into the blood supply of myomas themselves, published about a year ago, SAMPSON (*Surg., Gyn., and Obst.*, 1913, xvi, 144) now reports the results of his investigations into the effect that the presence of such tumors has upon the circulation of the uterus. The method pursued in both these lines of investigation has been to inject large numbers of myomatous uteri with various substances, in some cases using colored gelatine masses, red for the arterial system, blue for the venous, in others, radio-impenetrable substances, and then to make slices of the organs in various directions, studying these by direct inspection and by means of radiographs. Sampson has found that small and moderate-sized subserous myomas (up to 10 cm. in diameter) do not disturb the uterine circulation, and do not alter menstruation. Larger subserous tumors may produce marked enlargement of the branches of the uterine artery from which they derive their nourishment, and may also give rise to large venous channels in their pedicle and in the peripheral zone of the uterus, but the "radial zone," immediately surrounding the endometrium, which is normally anemic, remains unaffected. There is therefore no excessive escape of blood into the uterine cavity in these cases, and menstruation in them also is unchanged. Occasionally, however, the large venous channels in the pedicle become injured by movements of the tumor, and give rise to hemorrhage into the peritoneal cavity. Intramural myomas do not appear to alter the arterial blood supply of the uterus to an appreciable extent, unless present in very large numbers, in which case the uterine arteries may be somewhat enlarged. The venous plexus of the myometrium may show about the tumors a localized, or even a general dilatation, varying with their size, and when the myomas are very numerous there may be an increase in the thickness of the uterine wall, due to an actual hypertrophy of the myometrium, to a dilatation of the venous plexus, or to a combination of both these factors. Such tumors do not greatly interfere with the circulation of the uterus, and do not usually alter menstruation, although they may indirectly cause menorrhagia or metrorrhagia, the factor of muscular